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Now Live: Tri-Agencies Release Guidance for Group Health Plan "No Gag Clause" Attestations

Employee Benefits & Executive Compensation Blog on **March 8, 2023**

On February 23, 2023, the Departments of Labor, Treasury, and Health and Human Services (the "Departments") issued new guidance (in the form of FAQs) implementing the No Surprises Act's prohibition on "gag clauses" in agreements between health plans and service providers. While the attestation requirement has been effective since December 27, 2020, the Departments had previously stated that, pending the issuance of guidance, plans, and issuers could rely on a good-faith, reasonable interpretation of the statute. The new guidance provides directions on how to submit the attestations, as well as further guidance on the types of provisions that the Departments consider to be "gag clauses."

By way of brief background, the No Surprises Act requires group health plans and issuers to attest annually that the plan or issuer does not have agreements with providers, networks, third-party administrators (TPAs), or other service providers that would directly or indirectly restrict the plan or issuer from: (1) disclosing provider-specific cost or quality-of-care information to the plan sponsor, referring providers, participants, or individuals eligible to participate in the plan, (2) electronic accessing de-identified claims and encounter information (consistent with applicable privacy protections) on a per-claim basis, or (3) sharing the information described in (1) or (2) with a business associate.

The new guidance requires that plans and issuers submit their first attestations on December 31, 2023, which will cover the period from December 27, 2020 (or, if later, the effective date of the plan or insurance coverage) through the date of attestation. Subsequent annual attestations will be due every December 31. Like prescription drug reporting, the attestations must be submitted through a dedicated CMS website. Some technical steps are required to register to submit the attestation, which can be found on the dedicated website.

In terms of who may submit the attestation: Self-insured plans may contract with a third-party administrator to submit the attestation on the plan's behalf; however, the obligation to make a complete and accurate attestation ultimately remains with the plan, not the TPA. For fully-insured plans, while the plan and the issuer are each required to annually submit the attestation, if the issuer submits an attestation on behalf of the fully-insured plan, both will be deemed to have satisfied the attestation requirement. The guidance clarifies that an issuer that offers both group health insurance and acts as a TPA for self-insured plans may submit a *single* attestation on behalf of itself, its fully-insured group health plan policyholders, and its self-insured health plan clients.

Separately, the new guidance provides additional details about the types of provisions that the Departments consider to be "gag clauses." The Departments clarify that gag clauses include restrictions on the disclosure of provider rates regardless of whether the TPA considers them "proprietary," or provisions that allow access to provider-specific cost and quality-of-care information only at a TPA's discretion. In addition, provisions that indirectly operate to restrict access to or disclosure of applicable information violate the prohibition on gag clauses—even if they don't expressly restrict disclosure. Consistent with the statute, the guidance notes that "reasonable restrictions" may be placed on public disclosure of certain information.

***Next Steps*:** While many plan sponsors have already reviewed service agreements to confirm the existence of any gag clauses and made necessary amendments, the new guidance on provisions considered to be "gag clauses" may require a second pass through the relevant agreements to confirm compliance. From a practical perspective, plan sponsors should coordinate the required reporting well in advance of the December 31st deadline to confirm the submission is completed correctly and on time.

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